COVERED CALIFORNIA POLICY AND ACTION ITEMS

April 7, 2016

2017 QUALIFIED HEALTH PLAN CONTRACT AND STANDARD BENEFIT DESIGN MODIFICATIONS

Anne Price, Director of Plan Management Division

2017 HEALTH PLAN BENEFIT DESIGNS

- There have been no changes to the 2017 medical benefit designs reviewed at the February board meeting
- The following changes reflect changes that are being made to the embedded pediatric dental benefits both for Individual and Small Group:
    - Clarified use of standard copay schedule for embedded pediatric dental benefits by adjusting dental service categories and removing individual procedures as categories
    - Added endnote standardizing administration of member cost share for medically necessary orthodontia
    - Revised existing endnote to clarify that QHP plan designs can include either copay or coinsurance pediatric dental benefits

CORRECTIONS TO THE 2017 DENTAL PLAN DESIGNS

Copay Schedule

- Removed outdated procedure codes and replaced with current CDT-16 codes
- Removed procedure codes not included in the benchmark plan

Dental Plan Designs

- Combined copay and coinsurance plan designs in a single document, as in previous years
- Created separate standard copay schedule referenced by both copay dental benefit plan designs as well as QHP plan designs
- Adjusted dental service categories in the plan design documents
- Added endnote standardizing administration of member cost share for medically necessary orthodontia
- Added endnote standardizing the exclusion of adult tooth whitening, implants and adult orthodontia
- Replaced diagnostic and preventative member cost share “$0/0%” with “No Charge” for consistency with QHP plan designs

QUALIFIED HEALTH PLAN (QHP) CONTRACT UPDATE

As discussed in the February board meeting, the 2017 – 2019 QHP Issuer Contract includes many meaningful changes that seek to improve clarity of the Exchange's expectation for carrier performance and continued forward movement for impacting the improvement in both the delivery and quality of care provided to consumers.

Material changes to the base language of the contract includes the following:

- New language that requires carriers to use best efforts to identify potential subsidy-eligible individuals for enrollment through the exchange
- New language regarding expectations for agent commission payments that require consistency in payment methodology per carrier with regards to enrollment period and plan metal tier
- Clarification and addition of language regarding expectation for implementation of appeals
- Requirements for meeting Exchange timelines for uploading carrier rates
- Remedies expanded to address QHP Issuer Default or Breach

UPDATED LANGUAGE TO QHP CONTRACT

Based on comments received to the proposed changes following the last board meeting, and after further discussions with the QHP Issuers, Consumer Advocates and other stakeholders, we've made some additional modifications to the proposed language in the 2017 – 2019 contract:

- 2.1.2 (b) - Further clarified expectation and timing of contractor to comply with all enrollment determinations, including those that result from an applicant's appeal of an Exchange determination. Language includes expectation of timing and providing notification to the exchange confirming change has been made.
- 3.1.5 - Requiring carriers comply with timing required for CalHEERS uploads or liquidated damages of $25,000 could apply to cover costs that are charged to the Exchange.
- 7.2.4 - Clarification that QHP Issuer default or breach language does not apply to a carrier's performance with relation to meeting targets set forth in the performance measures in Attachment 14. Added additional language to address that reasonable efforts will be made between the Exchange and Issuer to resolve a non-material breach prior to instituting any interim remedies.
- 2017 performance standards in Attachment 14 (2.2,2.3, and 2.6) will have a pilot period prior to implementation and assessing performance penalties.
- Revisions to quality requirements that relate to exclusion requirements of outlier providers, all line of business reporting and percentage of facility reimbursement that is tied to quality and value. More detail will be presented in subsequent discussion.

QUALITY AND DELIVERY SYSTEM REFORM

Peter V. Lee, Executive Director
Anne Price, Director Plan Management Division

COVERED CALIFORNIA'S CORE BUILDING BLOCKS FOR IMPROVING QUALITY AND LOWERING COSTS

Strengthen already value-based, patient-centered benefit design to improve access to primary care.

Providers must meet quality standards without exception to provide safe care for all, including racial and ethnic groups.

Adopt payment strategies that support quality performance.

Be sure consumers get the right care and the right time -- adopt proven models of primary care and integrated delivery models.

Provide tools to consumers so they can make informed choices when selecting providers.

COVERED CALIFORNIA: PROMOTING THE TRIPLE AIM*

DIAGNOSIS

1. Many consumers fail to receive effective care, with nearly half of adults failing to receive recommended care.
2. Health care costs are far higher in the United States than any other developed country and costs have historically risen at twice the rate of GDP — resulting in higher costs to taxpayers, employers and consumers.
3. Market forces have not been effective in getting consumers the best value — multiple third-party payers have not worked together to reward value, and consumers have not had the tools or incentives to make better choices.

COVERED CALIFORNIA'S SOLUTION

1. Promote robust changes in measurement, payment and consumer tools that will benefit not only Covered California enrollees but will also help foster changes in how care is delivered.
2. Align payments and other efforts with those of CMS, CalPERS and other major private and public purchasers — promoting improvement with coordinated market signals.
3. Put the consumer at the center of all solutions — considering how they will benefit.

* See Covered California Individual Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy – 2016 (http://bit.ly/1MSHEfQ)

COVERED CALIFORNIA: ENSURING THE RIGHT CARE AT THE RIGHT TIME

DIAGNOSIS

1. Many consumers — especially the newly insured — do not have an entry point for care, such as a primary care clinician.
2. Patient care is often fragmented and uncoordinated, resulting in care that delivers inconsistent outcomes and high cost.
3. Payment has been based on “more is better” (the fee-for-service model) and not payments that reward outcomes and effective coordination.

COVERED CALIFORNIA’S SOLUTION

1. Require all plans, regardless of model, to assign a primary care clinician to Covered California enrollees within 30 days of their health plan coverage date.
2. Plans must change payments to incentivize enrollment and pay to reward advanced models of primary care, including patient-centered medical homes and integrated health care models, such as accountable care organizations.
3. Implement patient-centered benefit designs that improve access to care when it is needed.

COVERED CALIFORNIA: PROMOTING AND REWARDING QUALITY CARE AT THE BEST VALUE

DIAGNOSIS

1. Payments for volume provide no rewards to hospitals and other providers to improve care and make it safer for their patients.
2. Many patients receive unnecessary care or actually suffer from avoidable harm – with an estimated 400,000 patients dying annually as a result of preventable avoidable harm.[1]
3. Studies show a wide variations in both cost and quality and NO correlation between higher cost and better care.

COVERED CALIFORNIA'S SOLUTION

1. Require plans to disclose information about providers' clinical quality, patient safety and patient experience.
2. Work with stakeholders to develop tools to address cost and quality outlier hospitals. As of 2019, plans will either exclude outliers or provide a justification for inclusion in the network.
3. Require plans to implement payment reform to reward outcomes and results in hospitals, rather than just volume, with increasing percentages of payments being tied to hospitals performance starting in 2019.

[1] James, John T., A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care. Journal of Patient Safety, 2013.

COVERED CALIFORNIA: REDUCING HEALTH DISPARITIES AND PROMOTING HEALTH EQUITY

DIAGNOSIS

1. While there are significant health disparities, the specific quality gaps vary dramatically by income level and ethnic group:
   - Latinos and African-Americans are more than twice as likely to be admitted to hospitals for uncontrolled diabetes than are Whites or Asian/Pacific Islanders.
   - African-Americans are less likely to receive treatment for major depressive disorder.
2. Not all health plans or health systems are effectively measuring health outcomes for California's most vulnerable populations, or targeting groups for improvement.

COVERED CALIFORNIA'S SOLUTION

1. Require health plans to improve the collection of self-identified racial/ethnic information.
2. Require health plans to track, trend and improve over time care related to diabetes, asthma, hypertension and depression across **all payers** to achieve target goals within reasonable timelines.

COVERED CALIFORNIA: GIVING CONSUMERS TOOLS TO MAKE THE BEST CHOICES

DIAGNOSIS

1. The wide variation in costs – even for covered services — is often unknown to consumers who do not have the right tools available to pick a provider based on cost and quality. For example, in San Francisco, Calif., the consumer's cost of treatment for appendicitis can vary between $1,276 and $6,250.[1]
2. It's hard for consumers to calculate their out-of-pocket costs, with two out of three individuals saying it is difficult to know how much specific doctors or hospitals charge for medical treatments or procedures.[2]

COVERED CALIFORNIA'S SOLUTION

1. Require plans to develop tools (online/mobile) that enable consumers to compare costs and quality when choosing a provider.
2. Require plans to promote consumers' access and use of a "personal health record."
3. Require plans to promote patient engagement and "shared decision-making" between patients and their providers.

[1] Insurance Company Payment is taken from California Healthcare Compare http://www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm

[2] Kaiser Family Foundation, Health Tracking Poll, April 2015.

2017 QUALIFIED HEALTH PLAN CONTRACT QUALITY REFORM MODIFICATIONS

Lance Lang, MD Chief Medical Officer, Plan Management Division

ALIGNED CMS AND EXCHANGE STRATEGY

Covered California is evolving its work with Qualified Health Plans from “tell us what you’re doing” to a required set of initiatives resulting in demonstrated improvement over time.

Aligned with CMS Quality Improvement Strategy starting in plan year 2017:

- Improved health outcomes
- Prevention of hospital readmission
- Improvement in patient safety and reduction in errors
- Reduction in health disparities
- Promotion of health and wellness

With emphasis on aligning financial incentives with each improvement strategy.

ATTACHMENT 7

2014-2016	2017
1. **Improving Care, Promoting Better Health and Lowering Costs**	1. **Improving Care, Promoting Better Health and Lowering Costs**
2. **Accreditation: NCQA, URAC or AAAHC**	2. **Provision & Use of Data and Information for Quality of Care**
3. **Provision and Use of Data and Information for Quality of Care**	3. **Reducing Health Disparities and Assuring Health Equity**
4. **Preventive Health and Wellness**	4. **Promoting Development and Use of Care Models**
5. **Access, Coordination, and At-Risk Enrollee Support**	5. **Hospital Quality**
6. **Patient-Centered Information and Communication**	6. **Population Health: Preventive Health, Wellness and At-Risk Enrollee Support**
7. **Promoting Higher Value Care**	7. **Patient-Centered Information and Communication**
8. **Drug Formulary Changes**	8. **Promoting Higher Value Care**
	9. **Accreditation: NCQA, URAC or AAAHC**

ARTICLE 1: IMPROVING CARE, PROMOTING BETTER HEALTH AND LOWERING COSTS

Covered California supports provider networks based on quality, satisfaction and cost efficiency standards to ensure that enrollees have access to quality care.

1. Provider network structure includes measurement that is based on quality.
2. Qualified health plans are expected to contract with providers and hospitals that demonstrate they provide quality care and promote patient safety at a reasonable price.
    - Providers with outlier poor performance in metrics targeted under Attachment 7 will not be included in the network by 2019 or contracted plans will report rationale for continued participation.
    - All performance standards, including clear definitions of “outlier poor performance,” will be established by Covered California based on: National benchmarks, analysis of variation in California performance, best existing science of quality improvement and effective engagement of stakeholders.
    - Quality improvement support is available for all clinical targets.
    - **Criteria for defining “outlier poor performance” will include consideration of hospital case mix and services provided in variation analysis.**
3. Improved data exchange across specialties and institutional boundaries as well as between health plans and contracted providers is critical to improving quality of care and successfully managing total costs of care.
4. **Performance standards will be measured based on Covered California enrollees only, with the exception of health disparities.**

ARTICLE 2: PROVISION AND USE OF DATA FOR IMPROVEMENTS IN QUALITY OF CARE DELIVERY

Covered California will coordinate annual reporting of all quality and delivery system reform requirements and targets using the following mechanisms:

- Provide contracted claims and clinical data for exchange enrollees as specified in Attachment 7 to use in the Exchange's Enterprise Analytics Solution (EAS).
- Report HEDIS, CAHPS, and other performance data for each product type as required for use in Covered California's Quality Rating System (QRS).
- Report work plan and annual progress of the federally-required Quality Improvement Strategy (QIS) through the annual certification application.
- Report on broader quality improvement and delivery system reform efforts through annual reporting in the Covered California eValue8 Request for Information included in the annual certification application.

ARTICLE 3: REDUCE HEALTH DISPARITIES AND ASSURE HEALTH EQUITY

Covered California recognizes that promoting better health requires a focus on addressing health disparities and health equity while recognizing that some disparity results from determinants outside the control of the health care delivery system. Requirements of the Contracted Health Plan will include:

- Increase self-reported identity annually 2017 and 2018, achieving **80 percent** by end of 2019.
- Track, trend and improve quality measures by ethnic/racial group using a combination of self-reported and proxy identification and by gender. Initial focus: diabetes, hypertension, asthma and depression.
- Report baseline percent of self-reported racial/ethnic identity and quality measure data for 2017 application for certification by **end of third quarter 2016**.
- Achieve Covered California targets for annual reduction in disparities.

All qualified health plans have been required to collect race, ethnicity and language data on their enrollees under SB 853 since 2003 — **73 percent of Covered California enrollees voluntarily self-report race, ethnicity and language data when applying for coverage**.

ARTICLE 4: PROMOTING DEVELOPMENT AND USE OF CARE MODELS — PRIMARY CARE

Covered California structured standard benefits to minimize enrollee cost share for primary care visits. In addition:

- For 2017, qualified health plans will ensure that all enrollees either select or are provisionally assigned to a personal care clinician **within 30 days of effectuation**. This requirement is not to be interpreted as requiring that primary care serve as a gatekeeper.
- Adopt and progressively expand a contracting and payment strategy that creates a business case for primary care physicians to adopt accessible, data-driven, team-based care (as alternatives to face-to-face visits and care by non-medical doctors) with accountability for improving triple aim metrics including total cost of care — a style of practice often called patient- centered medical home (PCMH).
- Cooperate in evaluating various PCMH accreditation and certification programs as well as other frameworks for defining a consistent standard for determining the percent of primary care provided by PCMHs for Covered California enrollees and for the plan's book of business.
- Apply this standard to determine a baseline that will be included in the application for certification in 2018 with progressively greater share of Covered California enrollees who receive care from PCMHs.

ARTICLE 4: PROMOTING DEVELOPMENT AND USE OF CARE MODELS — ACCOUNTABLE CARE ORGANIZATION OR INTEGRATED HEALTH CARE MODEL

Covered California adopted a modified version of the description of an integrated health care model (IHM) from CalPERS: **A system of population-based care, coordinated across the continuum including multi-discipline physician practices, hospitals and ancillary providers, integrated information systems and accountable for the triple aim.**

Qualified health plans will:

- Describe their model for implementing Accountable Care Organizations (ACOs) or IHMs.
- Report the percent of Covered California and total enrollees that receive care from the ACO or IHM in the application for certification for 2017.
- Report how these models ensure accountability for triple aim metrics including both quality and total cost of care across specialties and institutional boundaries.

Covered California will establish targets for a progressively greater share of enrollees for whom care is provided under these models.

ARTICLE 5: HOSPITAL QUALITY AND SAFETY

- Qualified health plans will implement a payment strategy for **acute general** hospitals that places reimbursement at risk or are subject to a bonus based on quality performance.
  - **Incremental implementation requirements target is 2 percent by 2019 with a plan to increase to 4 percent by 2021 and 6 percent by 2023.** Each plan will structure this according to their own priorities including HACs, readmissions, or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS) scores. **If readmissions are included, that will not be the only measure.**
- Report the performance of contracted network hospitals managing avoidable complications.
- Only contracts with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees will be allowed. Providers with outlier poor performance on hospital safety will not be included in the network by 2019 or contracted plans will document each year in its application for certification the rationale for continued contracting and efforts the provider is undertaking to improve performance. **Rationale will be released to the public by Covered California.**

ARTICLE 5: HOSPITAL QUALITY — APPROPRIATE USE OF C-SECTIONS

- Qualified health plans will report the performance of network maternity hospitals in meeting the national Healthy People 2020 goal of 23.9 percent delivery by C-section for low-risk first pregnancies in the 2017 certification application.
- Covered California will:
  - Set annual targets for increasing the number of hospitals that meet the goal of 23.9 percent for low-risk first pregnancies.
  - Report on how physicians and hospitals are reimbursed for maternity services such that there is no financial incentive for surgical delivery.
- Only contract with providers and hospitals that demonstrate they provide quality care and promote the safety of Covered California enrollees will be allowed. Hospitals with C-section rates for low-risk deliveries above 23.9 per cent will not be included in the network by 2019 or contracted health plans will document each year in the application for certification the rationale for continued contracting and efforts the provider is undertaking to improve performance.

ARTICLE 6: POPULATION HEALTH — PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

- Contracted Health Plans will report the number and percent of enrollees who have used preventive care, tobacco cessation and obesity management services in the annual application for certification.
- Report on any participation in evidence-based community health and wellness initiative, such as those recommended by the Community Preventive Services Task Force in 2017, CMS Healthy Communities Initiative or other similar pilots.
- Report the results of ongoing health assessments and incorporate into monitoring and management through the annual application for certification. **Qualified health plans will ensure that appropriate protections from disclosure are in place, and will advise enrollees on how the information will be used.**
- Report programs to proactively identify and manage at-risk enrollees.
- Provide support to at-risk enrollees transitioning to or from coverage under Covered California.

ARTICLE 7: PATIENT-CENTERED INFORMATION AND COMMUNICATION AND COST TRANSPARENCY DECISION SUPPORT TOOLS

- By 2018, qualified health plans will report a plan to provide either online tools or phone alternatives that allow enrollees **to understand their share of cost for medical services.**
- Report on tools provided with the percent of enrollees who use such tools in the annual application for certification.
- By 2019, report on strategy to inform enrollees of the quality performance of providers with emphasis on target metrics for hospital quality defined in Attachment 7.
- **Qualified health plans agree to monitor care that is provided out of network to ensure that consumers understand that their cost share will likely be higher and are choosing out of network care intentionally.**

ARTICLE 7: PROMOTING HIGHER VALUE CARE AND REDUCING OVERUSE THROUGH CHOOSING WISELY

- Covered California requires deployment of tools to support enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their provider. Shared decision-making is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.
- One such set of decision aids is Choosing Wisely. National organizations representing medical specialists asked their providers to “choose wisely” by identifying tests or procedures commonly used in their field whose necessity should be questioned and discussed.
- Qualified health plans will join Covered California in partnership with the Department of Health Care Services and CalPERS in a statewide multi-stakeholder workgroup to support reduction of overuse through Choosing Wisely. Targeted conditions include: C-sections, opioid prescriptions and imaging for low-back pain.

ARTICLE 8: PROMOTING HIGHER VALUE CARE

Covered California requires that quality and delivery system improvement strategies include payment models that align.

Covered California has established requirements for the following initiatives:

- Advanced primary care or patient-centered medical homes (Article 4)
- Integrated health care models or Accountable Care Organizations (Article 4)
- Appropriate use of C-sections (Article 5)
- Hospital patient safety (Article 5)

Requirements of the qualified health plan will include reporting in the annual application for certification on experience with other innovations in payment or market-based incentives. These will include:

- Participation or alignment with CMMI innovative payment models such as the oncology or joint replacement model
- Adoption of new alternative payment models associated with the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

ARTICLE 9: ACCREDITATION

All contracted health plans are required to be accredited by NCQA, URAC or AAAHC.

2017 QUALITY INITIATIVE COLLABORATION

Covered California would like to acknowledge and thank many stakeholders for their collaboration in our 2017 quality planning and strategy. Our meetings, starting in July 2015, included:

- Individual three-hour meetings with each of the 12 qualified health plans
- Deep dive three-hour meetings with all health plans together with other state purchasers, stakeholders and content experts on the following subjects: payment reform, hospital safety (two meetings), appropriate use of C-Section for low risk deliveries and advanced primary care.
- Public input from advocates, providers, regulators, health plans and other health policy experts such as the Plan Management Advisory Group, Quality Subcommittee Work Group, a session with consumer advocates and an initial meeting of a multi-stakeholder work group on Measure Specifications.
- Multi-stakeholder meetings will continue to complete work on measure specifications by June 1, 2016, collaborate on implementation of primary care requirements and define “outlier poor performance.”

SPECIAL ENROLLMENT PERIOD POLICIES

Anne Price, Director of Plan Management Division

SPECIAL ENROLLMENT BACKGROUND

- Consumers may enroll for coverage through Covered California outside of the open enrollment period if they qualify for coverage due to a “triggering” event.
  - Covered California currently requires consumers, upon application during the special enrollment period, to attest that they qualify for coverage indicating the triggering event for qualification. If they are not able to choose a triggering event, or select “other” while enrolling, they will be contacted by a customer service representative to confirm eligibility.
  - Consumers who enroll off-exchange (e.g. directly through a carrier) are subject to the carrier’s rules for verifying eligibility which usually includes providing documentation
- Concerns have been raised that because consumers can enroll through the exchange through attestation only, without providing documentation, consumers may be selectively enrolling when they need medical care rather than enrolling through open enrollment or through a qualifying event in the special enrollment period.
- Increased enrollment that is selective, only when medical care is necessary and not through open enrollment or a qualifying event, increases cost significantly and will impact long term affordability that could threaten sustainability of the program.
- It is imperative to address concerns of selective enrollment to preserve the good risk mix of the individual market and to minimize potential premium increases that will ultimately impact all consumers.
- We will continue to have a pre-enrollment verification process for on-exchange enrollment in 2016 that will be updated in 2017 as we collect more data and information to have clear direction on how the verification process could be modified to address potential selective enrollment that may be occurring.
- Covered California staff will continue to engage carriers and various stakeholders to discuss potential options and process improvement for enhancing special enrollment verification.

SPECIAL ENROLLMENT POLICY GUIDING PRINCIPLES

- Covered California will implement a special enrollment policy that assures only eligible individuals are enrolled, preserving the integrity of the risk mix in the Individual market and supporting long-term affordability for all consumers.

- The Special Enrollment policy will not be overly burdensome to members.
  - Use of electronic verification will be maximized
  - Use of new or alternative forms of documentation or attestation may likely be required

- Documentation should be verified prior to effectuation of coverage so consumers have peace of mind that they will not be financially responsible for medical care they have received beyond their intended cost sharing, so verification of eligibility cannot take an unreasonable length of time that could result in access to care concerns.

- The process must consider technology capabilities and resource limitations.

COVERED CALIFORNIA 2016-17 SPECIAL ENROLLMENT POLICY

- Covered California will continue to have a pre-enrollment verification process in 2016 using attestation only, but we are requesting modification to regulations that will allow for a random sampling for verification of the SEP attestation that will assess if consumers who enroll during special enrollment in 2016 have appropriate documentation.
- Covered California will enhance language on the application at the point of attestation that requires consumers' acknowledgement of their potential financially liable if they are determined to have enrolled attesting that they meet qualifying criteria when they do not.
- Notifications will also be updated to reflect Covered California's intent to perform a random sampling for verification where documentation may be requested to support the consumer's qualifying event.
- In 2017 Covered California will phase in electronic verification of documents and collection/verification methods for non-electronic documents.
- We will continue to work with Qualified Health Plans to identify alternative documentation that could be used to verify special enrollment eligibility and request carriers to pilot these methods on their off-exchange enrollment to understand potential opportunities for implementation for on-exchange enrollment.
- The results of the random sampling for verification, analysis of more complete claims data, and experience of alternatives used for off-exchange documentation will inform Covered California as we look to further update the special enrollment verification process that will preserve the integrity of the Individual market risk pool.

INDIVIDUAL ELIGIBILITY AND ENROLLMENT REGULATIONS READOPTION (DISCUSSION)

Bahara Hosseini, Legal

INDIVIDUAL ELIGIBILITY AND ENROLLMENT REGULATION CHANGES

- Covered California removed some terms from the definition section that were no longer applicable to the regulations.
- Covered California updated the definition of Qualified Health Plan (QHP) to include Qualified Dental Plan (QDP), revised the definition of QDP.
- The regulations were also amended to include the eligibility requirements for enrollment in a QDP.
- Covered California amended language regarding binder payments that will allow carriers to apply premium thresholds to initial payments as well as the subsequent premium payments.
- Covered California amended language regarding verbal unconditional withdrawal of an appeal request to make the regulations consistent with the current process.
- Covered California added/amended language throughout the regulations to comply with the recent federal regulations set to go into effect May 9, 2016 (e.g., adding the random sampling verification process for employer-sponsored coverage).

INDIVIDUAL ELIGIBILITY AND ENROLLMENT REGULATION CHANGES

- Covered California added language to specify the random sampling verification process for qualifying life events (QLEs) that trigger a Special Enrollment Period (SEP).
- Covered California will accept the qualified individual's or the enrollee's attestation that he/she meets a QLE triggering an SEP subject to the following random sampling verification process:

1. Covered California may select a random sample of the qualified individuals or enrollees who attested to a QLE and request, in writing, that they provide satisfactory documentary evidence as proof of the QLE they attested to.
2. The qualified individual or the enrollee must provide the requested document(s) to Covered California for verification.
3. If Covered California is unable to verify the provided document(s), Covered California will:

   (A) Determine the qualified individual or the enrollee ineligible for an SEP;
   (B) Notify the enrollee and the enrollee's employer, as applicable, regarding the determination; and
   (C) Implement such eligibility determination prospectively, in accordance with the applicable effective dates specified in the regulations (§ 6496(j)-(k)).

SHOP APPEALS REGULATIONS (ACTION)

Kirk Whelan, Director, Outreach and Sales Division

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) APPEALS REGULATIONS

Title 10, Chapter 12, Article 6 – General Eligibility Appeals Requirements for SHOP (Section 6540 et seq.)

- Seeking Board authorization to file permanent rulemaking package with the Office of Administrative Law.
- Final package contains minor changes to language in order to ensure clarity and compliance with federal requirements. It also includes some additional requirements to the appeals decisions and notifications that are sent to appellants. No other substantive changes.
- Resolution **2016-12**

CERTIFIED APPLICATION COUNSELOR PROGRAM REGULATIONS FOR DISCUSSION

Kirk Whelan, Director, Outreach and Sales Division

CERTIFIED APPLICATION COUNSELOR PROGRAM

In April 2015, the Covered California Board approved the Emergency Rulemaking for the Certified Application Counselor Program:

- Almost 12,000 enrollments during the Third Open Enrollment
- Almost 400 Certified Entities and over 2,000 Counselors
- Over 50% of the Program Entities are Non-Profit Community Based Organizations and Licensed Health Care Clinics

CERTIFIED APPLICATION COUNSELOR PROGRAM

The Proposed Amendment to the CAC Regulations:

§6858 (e) Costs.

- Background check costs for individuals seeking certification under this Article shall be paid by the Exchange. ~~prior to and including June 30, 2016.~~
- ~~After June 30, 2016, background check costs for individuals seeking certification under this Article shall be paid by the applicant.~~